Oregon Provider Medicaid ID Application

Please return this completed form by email to MedicaidProvNet@PacificSource.com or fax to **541-225-3643**. All fields are required if applicable.

Request Information

Contact Name (individual completing form) ______________________

Effective Date[1] ______________________ Phone ______________________

Provider Information

Name ______________________

Birth Date ______________ Social Security No. ______________________

Specialty ______________________

License No. ______________________ NPI No.[2] ______________________

License Effective Date ______________________ Expiration Date ______________________

Licensing Board ______________________ State of Issue __________

Primary Taxonomy Code[2] ______________ Description ______________________

Secondary Taxonomy Code[2] ______________ Description ______________________

Other Taxonomy Code[3] ______________ Description ______________________

[1] If more than six months from the date the state receives the request, your DMAP liaision will contact you for additional information.
[2] Entries must match your registration with the National Plan & Provider Enumeration System. See provider type by visiting the link below.

For DHS/OHA Provider Types, go to Oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx.

Service Location

Street Address ______________________

City ______________________ State __________ ZIP+4 ______________

County ______________________ Phone ______________

Mailing Address (if different) ______________________

City ______________________ State __________ ZIP+4 ______________